Medical Examination Report
For Massachusetts Hoisting License Fitness Determination

1. APPLICANT INFORMATION — Applicant completes this section

Applicant's Name (Last, First, Middle)	Social Security No.	Birthdate M / D / Y	Age	Sex ☐ M ☐ F	☐ N ☐ F ☐ F
Address	City, State, Zip Code	Work Tel: ( ) Home Tel: ( )			D

2. HEALTH HISTORY — Applicant completes this section, but medical examiner is encouraged to discuss

Yes	No		Yes	No		Yes	No	
☐	☐	Any illness or injury in last 5 years?	☐	☐	Lung disease, emphysema, asthma, chronic bronchitis	☐	☐	Fainti
☐	☐	Head/brain injuries, disorders or illnesses	☐	☐	Kidney disease, dialysis	☐	☐	Sleep daytime slee
☐	☐	Seizures, epilepsy	☐	☐	Liver disease			
		☐ medication _____	☐	☐	Digestive problems	☐	☐	Stroke
☐	☐	Eye disorders or impaired vision (except corrective lenses)	☐	☐	Diabetes or elevated blood sugar controlled by:	☐	☐	Missi
☐	☐	Ear disorders, loss of hearing or balance.			☐ diet	☐	☐	Spina
☐	☐	Heart disease or heart attack; other cardiovascular condition			☐ pills	☐	☐	Chron
		☐ medication _____			☐ insulin	☐	☐	Regul
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)	☐	☐	Nervous or psychiatric disorders, e.g., severe depression	☐	☐	Narcc
☐	☐	High blood pressure ☐ medication _____			☐ medication _____			
☐	☐	Muscular disease	☐	☐	Loss of or altered consciousness			
☐	☐	Shortness of breath						

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications medications) used regularly or recently.

_____

_____

_____

I certify that the above information is complete and true. I understand that inaccurate, false or missing information r and my Medical Examiner's Certificate.

_____

Applicant's Signature

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the appl potential hazards of medications, including over-the-counter medications, while operating hoisting equipment.)

_____

_____

_____

_____

TESTING (Medical Examiner completes Section 3 through

3. VISION

Standard: At least 20/40 acuity (Snellen in each eye with or without correction. At least 70 meridian measured in each eye. The use of corrective lenses should be noted on the Medical

INSTRUCTIONS: *When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 2(ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use mus qualified.*

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye			
Left Eye			
Both Eyes			

Applicant can recognize and disti control signals and devices showin and amber colors?

Applicant meets visual acuity rec wearing: ✍ corrective Lenses

Monocular Vision: ✍ Yes ✍ No

Complete next line only if vision testing is done by an ophthalmologist or optometrist

Date of Examination	Name of Ophthalmologist or Optometrist (print)	Tel. No.	License No. / State of Issue

4. HEARING

Standard: a) Must first perceive forced whispered voice=5 ft., with or without hearing aid, or b) average

✍ Check if hearing aid used for tests. ✍ Check if hearing aid required to meet standard.

Numerical readings must be recorded

a) Record distance from individual at which forced whispered voice can first be heard	Right Ear Feet	Left Ear Feet

b) If audiometer is used, record hearing loss in decibels.	Right Ear 500 Hz	 1000 Hz	 2000 Hz

5. BLOOD PRESSURE / PULSE RATE

Numerical readings must be recorded

Blood Pressure	Systolic	Diastolic

Applicant qualified if <= 160/90 on initial exam

Pulse Rate	Beats per minute

6. LABORTORY AND OTHER TEST FINDINGS

Numerical readings must be recorde

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problems.

Urine Specimen	Specific Gravity

Other Testing: *(Describe and record)*

7. PHYSICAL EXAMINATION Height:_____(in.) Weight:_____

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any Y
space below and indicate whether it would affect the applicants ability to operate heavy equipment

BODY SYSTEM	CHECK FOR:	YES	NO	BODY SYSTEM	CHECK FC
General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse			Abdomen and Viscera	Enlarged liver, e masses, bruits, h abdominal wall r
Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos, strabismus uncorrected by corrective lenses, retinopathy, cataracts, aphakia, glaucoma, macular degeneration			Vascular System	Abnormal pulse carotid or arteria veins.
Ears	Middle ear disease, occlusion of external canal, perforated eardrums			Genito-urinary System	Hernias
Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.			Extremities – limb impaired. Applicant may be subject to SPE certificate if otherwise qualified	Loss or impairm toe, arm, hand, f limp, deformities weakness, paraly edema, hypotoni grasp and prehe to maintain steer Insufficient mob in lower limb to properly.
Heart	Murmurs, extra sounds, enlarged hear, pacemaker			Spine, other musculoskeletal	Previous surgery limitation of mot
Lungs and chest, not including breast examination	Abnormal check wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, dyspnea, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or xray of chest.			Neurological	Impaired equilib or speech patter asymmetric deep sensory or positi abnormalities, ab and Babinski's r

COMMENTS

Note certification status here.

- ☐ Meets standards in 49 CFR 391.41; qualifies for a 2 year certificate
- ☐ Does not meet standards
- ☐ Meets standards, but periodic evaluation is required, due in _____ months.
- ☐ Temporarily disqualified due to (condition or medication) _____
- ☐ Wearing corrective lenses
- ☐ Wearing hearing aid
- ☐ Accompanied by a _____waiver / exemp
- ☐ Skill Performance Evaluation (SPE) Certificate
- ☐ Qualified by operation of 49 CFR 391.64

Medical Examiner's Signature:_____

Medical Examiner's Name (print):_____

Address:_____

Telephone Number:_____

Date of Medical Examination:_____